VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ ANTI-OBESITY MEDICATIONS~

Prior Authorization Request Form

Effective November 01, 2001, Vermont Medicaid established coverage limits and criteria for prior authorization of non-amphetamine based diet medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Anti-Obesity drug prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____ Fax#:_____

Address: _____

_____

Contact Person at Office: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Drug Requested:_____ **Strength & Frequency:**_____ **Length of therapy:**_____

1. **Current Body Mass Index (BMI):**_____**Height:**_____**Weight:** _____ **Waist Circumference:**_____
2. **Does the patient have any of the following conditions? (Please check all that apply.)**

   ☐ **Hypertension** ☐ **Obstructive Sleep Apnea** ☐ **Diabetes** ☐ **Dyslipidemia** ☐ **Coronary Heart Disease**
3. **Has the member been participating in a weight loss treatment plan (nutritional counseling, an exercise regimen, and a calorie and fat restricted diet) for the past 6 months?** ☐ **YES** ☐ **NO**
   If YES, Please provide a description of the program, dates, and results: _____
   _____
   _____
4. **Will this medication be used in addition to a weight loss treatment plan (nutritional counseling, an exercise regimen and a calorie and fat restricted diet)?** ☐ **YES** ☐ **NO**
   Please explain: _____
   _____
5. **Does the patient have any contraindications for use of this medication? (Please see table below.)**

   ☐ **YES** ☐ **NO** **If YES, please explain:** _____

Alli, Xenical:	Malabsorption syndrome, cholestasis, pregnant or lactating, hyperoxaluria, calcium oxalate nephrolithiasis
Meridia:	Concomitant MAOI use, concomitant use of centrally acting appetite suppressants, poorly or uncontrolled HTN, pregnant or lactating, severe renal or hepatic dysfunction, hx of CAD, CHF, arrhythmias, stroke, bulimia or anorexia nervosa
Diethylpropion, Benzphetamine, Phendimetrazine, Phentermine:	Advanced arteriosclerosis, agitated states, concomitant use of MAOI, concomitant use of other CNS stimulants, glaucoma, hx of drug abuse, hypersensitivity or idiosyncratic reaction to sympathomimetic amines, moderate to severe HTN, hyperthyroidism, pregnant, symptomatic cardiovascular disease

Prescriber Signature:_____ Date of this request:_____

Last Updated 06/08